



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 BUREAU OF COMMUNICABLE DISEASE CONTROL AND PREVENTION  
**DIAGNOSTIC SERVICES ELIGIBILITY/AUTHORIZATION (TB)**

FAX TO: (573) 526-0234

CLIENT'S NAME			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS	CITY	COUNTY	ZIP CODE
TELEPHONE	SOCIAL SECURITY NUMBER	BIRTHDATE (MONTH/DAY/YEAR)	
1. IS PATIENT COVERED BY MEDICAID OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	2. IS PATIENT COVERED BY ANY OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	3. IS CLIENT COVERED BY VA BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

I affirm by my signature (mark) that the above statements are true to the best of my knowledge. I understand Diagnostic Services are for evaluation of TB infection/disease (initial office visit, chest x-ray) with subsequent follow-up visits if necessary and approved through the \_\_\_\_\_ County/City Health Department by the Disease Investigation Unit. **Diagnostic Services will only pay for office visits, chest x-ray and sputum induction (if needed). Any other services obtained are not covered and are the responsibility of client (e.g. CT scans and routine labs).**

I also give my permission to the \_\_\_\_\_ County/City Health Department to share needed information with the provider to obtain these services and also authorize the care provider to share information with the County/City Health Department.

SIGNATURE OF CLIENT OR PARENT/GUARDIAN (IF CLIENT IS A MINOR)	DATE
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DATE PPD TEST GIVEN	DATE READ	RESULTS	RISK FACTORS
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PHYSICIAN/CLINICIAN PROVIDER
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PHYSICIAN ADDRESS	CITY	COUNTY	TELEPHONE
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LOCAL COUNTY HEALTH DEPARTMENT (LPHA)	LPHA EMPLOYEE SIGNATURE	DATE
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DHSS USE ONLY		
PRE-AUTHORIZATION NUMBER	DATE AUTHORIZED	AUTHORIZED BY

TYPE OF SERVICE NEEDED	UNITS AUTHORIZED
<input type="checkbox"/> INITIAL OFFICE VISIT (99205)	
<input type="checkbox"/> SUBSEQUENT OFFICE VISITS (99215)	
<input type="checkbox"/> CHEST X-RAY (71046)	
<input type="checkbox"/> CHEST X-RAY INTERPRETATION (71046A)	
<input type="checkbox"/> INDUCED SPUTUM COLLECTION (89350)	
<input type="checkbox"/> OTHER	